Medical Home Initatives

Medical Home Expansion for Clients who are Aged, Blind or Disabled

Background

In 2006, Governor Chris Gregoire formed a Blue Ribbon Commission (BRC) to develop a five-year plan to increase access to affordable health care for Washington residents. Commission findings were published in a final report dated January 2007. Legislation passed as a result of the BRC Final Report included the Blue Ribbon Commission on Health Care Costs and Access—Implementing Recommendations (E2SSB 5930). This legislation aims to increase the provision of high quality, affordable health care to Washingtonians.

Section 4 of E2SSB 5930 mandates the Department of Social and Health Services (DSHS) to work with the Department of Health (DOH) to design and implement Medical Homes for clients who are aged, blind or disabled. This is to be done in conjunction with current chronic care management programs to improve health outcomes, access, and cost-effectiveness. Programs must be:

- Evidence based;
- Use health information technology to improve quality;
- Acknowledge the lead role of the Primary Care Provider (PCP) and provide financial and other supports to help them carry out their role in chronic care management; and
- Improve coordination of primary, acute, and long-term care for clients with multiple chronic conditions.

The department is further mandated to consider expansion of existing Medical Home and chronic care management programs and to build on the Washington collaborative initiative. The department is instructed to use best practices to identify clients best served under current predictive modeling initiatives.

Medical Home Best Practices

Office of Quality and Care Management (OQCM) staff in the Division of Healthcare Services researched Medical Home development and implementation in seven states. Each of the seven programs differed in payment structure, covered populations and which Medical Home components were emphasized and financed. In terms of payment structure, two states had traditional Managed Care arrangements and five had Primary Care Case Management (PCCM) or Enhanced PCCM (EPCCM) programs. Traditional Managed Care arrangements feature capitation and special services for clients who are aged, blind or disabled. Traditional PCCM programs pay a small case management fee to PCPs per member per month. EPCCM programs have additional requirements, such as quality standards, emphasize partnership and support of PCPs and generally pay PCPs more. Most PCCM/EPCCM programs are Fee-for-Service; they can be risk-based even when not capitated.

Despite the structure, the following Medical Home components were common in all seven states:

- An emphasis on access to primary care and continuity of care;
- Funding of care management or care coordination staff;
- Funding of Disease Management focusing on client education; and
- Mandatory Enrollment into PCCM/EPCCM or Managed Care for eligible clients, including clients who are aged, blind or disabled.

Additional Medical Home components and enhanced services vary from state to state and include:

- Coverage of preventive dental services not normally covered by Medicaid
- Patient Advice Telephone Line answered by health care workers 24/7
- Pay for Performance Incentives to Providers for clinical outcomes (HgA1c control for diabetics) and infrastructure improvements (extended office hours)
- On-site Care Managers
- Patient Navigators to reach the underserved
- Client education classes on Diabetes, Nutrition, Asthma, Parenting, etc.
- Local organization of PCPs into networks that provide structure and support for PCPs
- Health information technology such as electronic medical records and client registries
- Utilization and quality data shared quarterly with PCP
- PCP notification of ED visits so PCP/care manager can follow up/intervene
- Patient health risk assessments

Recommendations:

The Medical Home Workgroup would like to explore several options, using the Logic Model[1] as a guide. We recommend starting in a few communities to gain support for a locally driven model. The Workgroup also recommends not allowing competition in a single county between different models (e.g. would not have competition between a managed care plan and a PCCM). Funding requests are for the 2009 – 2011 budget cycle.

A. Support Existing Medical Home Best Practices Through Enhanced PCCM Pilots

Some counties where a provider network or local efforts are already in place include:

Whatcom County

Whatcom County received millions of dollars in grant support for its *Pursuing Perfection* model. One of their major accomplishments is the development of the Whatcom Health Information Network (WHInet). WHInet is a secure, health care electronic communication channel (Intranet) in Whatcom County. Using frame relay technology, it connects the hospital, payers, all network physician offices and community health services. Providers can check results of patients' hospitalization and lab work, receive alerts to medication conflicts, duplicate therapies and allergies, send legible scripts to the pharmacy, track diabetic patients and review medical references, all online.

Cowlitz County

The Child & Adolescent Clinic in Cowlitz County is a group of 9 pediatricians, 4 pediatric nurse practitioners, and over 40 support staff that serve as medical home to the children and teens of Longview/Kelso and surrounding communities. With urgent care hours and an after hours phone number they are committed to providing comprehensive and compassionate care. There are 15 educational Programs and Services topics available to patients/families on the well kept website and available in the clinic. Also on the website is a page dedicated to reliable "Resources for Parents" with various links to medical information.

[1] A logic model is a picture of how an organization does its work—the theory and assumptions underlying the program. A logic model links short and long term outcomes with program activities, resources, and principles.

Pierce County
Northwest Physicians Network (NPN) is an independent physician association in Pierce and South King Counties. NPN contracts with Molina Healthcare (MHC) for HO and currently has 13,000 MHC enrollees in a fully capitated arrangement with MHC. NPN physicians also see Fee-for-Service clients who are aged, blind or disabled. The NPN approach to Medical Homes is patient centered, data driven, and includes care and disease management components. Providers are given incentives for clinical performance and participating in quality improvement activities.

Yakima
Children's Village in Yakima is a facility that serves children with special health care or developmental needs and their families. It is a family centered organization and aims to meet the needs of each individual family. Children's Village provides a wide range of evaluative and diagnostic services, intervention programs, and a complete series of therapies, as well as support programs, pediatric dentistry, and consultation services. Community and family support are taught and encouraged.

B. Expand Existing Managed Care Programs to Serve Clients who are Aged, Blind or Disabled:
Contract provisions would need to include medical home requirements. This may not be feasible statewide due to provider network restrictions.

1. Expand the current Washington Medicaid Integration Partnership (WMIP) through MHC in Snohomish County into new county or new counties to be determined.
2. Expand the Healthy Options program to include children who are aged, blind or disabled.
3. Expand the Healthy Options program to include adults who are aged, blind or disabled.
4. Expand the integrated mental health model currently being used with GAU to other populations.

C. Expand Existing Medical Home Component of Chronic Care Management:
King County Health Partners: King County's Area Aging on Aging has been developing a medical home infrastructure as part of the current Chronic Care Management program. Possibilities of expansion might include adding providers or expanding the population served, e.g. long term care or children.